REQUEST FOR PAYMENT FOR INTERPRETER SERVICES
ATTACHMENT – 700-02-DD

(To be completed by SC/EI Provider and sent to DDSN District Office)

- This form is used by DDSN to reimburse service coordination and early intervention providers for the use of interpreter services in accordance with Title VI of the Civil Rights Act of 1964.
- Providers are encouraged to arrange and pay for interpreter services, and then request reimbursement from DDSN since there is likely to be a three (3) to four (4) week lag from time of request to time of reimbursement from DDSN.
- Providers are encouraged to submit monthly invoices to DDSN for reimbursement of all interpreter services provided in that month.

Provider: _____ **Date:** _____

	Name	**Age**	**SS#**	**Type of Interpreter Service (e.g., Spanish, American Sign Language, Braille, etc.)**	**Amount Paid ($)**
1.					
2.					
3.					
4.					
5.					
				Total Dollar ($) Amount Requested	

For DDSN Use Only:

District I _____ District II _____

Approved Amount: $_____